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Evidence Review

Lesbian, Gay, Bisexual, and Transgender Parents Seeking Health Care for Their Children: A Systematic Review of the Literature

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ABSTRACT

Background: Few studies have examined the issues faced by lesbian, gay, bisexual, and transgender (LGBT)-parented families in relation to their access to and satisfaction with healthcare services for their children. It is thought that LGBT individuals have experienced negative interactions with the healthcare environment.

Aims: To systematically review the literature investigating the experience of LGBT parents seeking health care for their children.

Methods: A search of the following databases: Cochrane Library, CINAHL, Embase, Google Scholar, Medline, PsychInfo, Science Direct, Sociological Abstracts, Proquest, Scopus, and Web of Science was conducted. Using the PRISMA flow chart and processes of the United Kingdom Centre for Reviews and Dissemination, we selected and analysed relevant studies.

Findings: Four studies that met the inclusion criteria were identified. Studies showed that while the experience of LGBT parents seeking health care was largely positive, strategies need to be implemented to improve the quality of healthcare services for LGBT families and ensure that their needs are met.

Discussion: Although many LGBT parents have positive experiences of health care, some still experience discrimination and prejudice.

Implications for practice: Specific educational interventions are needed to support LGBT parents seeking health care for their children.

Conclusions: Further research is required to explore LGBT-parented families' experiences of healthcare services, and this should include children's experiences.

KEYWORDS lesbian, gay, transgender, bisexual, parents, family-centred care, sexuality, homosexuality

BACKGROUND

A challenge for healthcare professionals in today's rapidly changing world is to become familiar with the community in which they practice. As our communities diversify, then so, too, do societal definitions of families and the way in which they are described. Family types and styles in the Australian social landscape have broadened to include same sex parented families. Healthy families are an

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important reflection on the health of a community, and knowledge of a community's uniqueness provides the foundation from which to develop strategies to promote family and community health. Healthcare professionals are an integral part of the delivery of services to families, and this paper is part of a larger project, which seeks to describe the experiences of Australian lesbian, gay, bisexual and transgender (LGBT) parented families seeking access to health care for their children, and which is being published elsewhere (Chapman et al. 2011, 2012a, 2012b, 2012c).

While literature exists describing the experiences of LGBT individuals in the healthcare environment (Allen et al. 1998; Albarran & Salmon 2000; Barbara et al. 2001; Beehler 2001; Cant & Taket 2006; Edwards & van Roekel 2009; Neville & Henrickson 2009), there is a paucity of current research exploring specifically the experiences of LGBT parents accessing health care for their children.

Parenting by LGBT persons is becoming increasingly common and more widely accepted (Ahmann 1999; Perrin et al. 2004; Telingator & Patterson 2008) and the exact number of these family groups is largely unknown (Millbank 2003). Many LGBT parents are reluctant to disclose their sexual identity (Ahmann 1999; Klitzman & Greenberg 2002; Neville & Henrickson 2009). Poor past experiences of health care may result in LGBT individuals being wary to disclose (Edwards & van Roekel 2009), and therefore they may employ strategies to shield themselves against possible negative experiences. This unwillingness to "come out" can often be related to concerns about discrimination and bullying (Barbara et al. 2001; Perrin et al. 2004; Polek et al. 2008). Such fears become increasingly significant when LGBT parents are accessing health care for their child (Perrin & Kulkin 1996; Perrin et al. 2004).

LGBT adults can find the healthcare system to be indifferent and at times hostile to their needs and concerns (Gold et al. 1994; Hinchliff et al. 2005). Prevalent heterosexist (Barbara et al. 2001) and suspected or perceived homophobic attitudes among healthcare providers (Eliason & Schope 2001) have resulted in anxiety and distress in LGBT persons.

SIGNIFICANCE AND PURPOSE

Despite increases in societal acceptance of homosexuality, prejudices remain (Crawford & Solliday 1996; Tate & Longo 2004). To varying degrees, some states within Australia allow some form of recognition to LGBT-parented families. However, in other states, these families remain invisible and do not have the same legal protection as heterosexual families (Tobin 2008). Invisibility within the setting of Western health care also occurs for same sex attracted women (McNair 2000) with failure to acknowledge a co-mother's parenting role being perceived as homophobia from the healthcare provider (Gartrell et al. 1999). Stigma towards LGBT parents can marginalise them (Weber 2008), and this highlights further the importance of training health professionals in issues related to sexuality and homophobia and in identifying and confronting personal and institutional bias (Stein & Bonuck 2001).

Although recent times have seen an increase in research about LGBT-parented families (Short et al. 2007), Millbank (2003) argues that in the absence of good-quality information, decision makers and policy makers may either ignore the existence of such families, or proceed on the basis of inaccurate or inappropriate assumptions. These concerns are significant for health professionals working in paediatrics; however, we located only a few studies that focus on LGBT parents' experiences of accessing health services for their children (Perrin & Kulkin 1996; Mikhailovich et al. 2001; McNair et al. 2008; Rawsthorne 2009).

This review aims to identify, summarise, and critique research on the experiences of LGBT parents seeking health care for their families and compare and contrast the findings.

PROCEDURE

Design

We followed recommendations of the United Kingdom Centre for Reviews and Dissemination (2009) for search methods, quality assessment data extraction, and analysis (Power & Franck 2008), and used a modified version of the PRISMA (2011) flow chart to demonstrate results of the searches.

Search Methods

We searched the following electronic databases from the indicated year until November 2010: Cochrane Library 1996; CINAHL 1981; Embase 1996; Google Scholar 2008; Medline 1996; PsychInfo 2002; Science Direct 1996; Sociological Abstracts 1952; Proquest 2008; Scopus 1996; and Web of Science 1972. A manual search of the procured articles' references was conducted to locate additional relevant papers. Only those articles written in English were included (although we assessed English abstracts of papers in other languages if available). Search terms were: lesbian, gay, transgender, bisexual, homosexual, gay patients, lesbian patients, sexual minorities, lesbian health, gay health with health-seeking behaviour, children, help-seeking behaviour, health services, homophobia, heterosexism, and healthcare providers.

Types of Studies

Studies included: descriptive, qualitative, and quantitative studies; randomised controlled trials (RCTs); quasi-experimental trials; pre- and post-intervention studies; case control studies. Abstracts of research reports, if the only source available (e.g., for studies in languages other than English), were included.

Studies excluded: single case studies, review articles, policy documents and papers, book chapters, commentary papers, essays, practice reports, and non-published theses.

Participants and Settings

We included LGBT people who were parents, and children of those families, and all types of health professionals.

Quality Assessment

We used a tool designed for a review of parent participation (Power & Franck 2008) with the authors' permission. Key components of the tool (which was based on guidelines of the Centre for Reviews and Dissemination 2009) related to sampling, design, intervention, and outcome measurement. To validate our method, we cross-checked the quality assessment with Greenhalgh (1997).

Data Collection and Synthesis

Searches were undertaken by three authors. Three authors screened the studies while two extracted the data. Four authors undertook quality assessment independently, while two analysed and synthesised the data, and crafted the findings, while all authors constructed, wrote, and edited the paper.

Data collected from the studies reviewed included design, number and types of participants, aims of the research, procedures and methods used, outcome measures, and main findings. The nature of the included studies directed the approach for analysis and synthesis (Table 1), using mainly qualitative assessment to allow for the different types of studies, and resulting conclusions about LGBT parents who seek health care for their children.

RESULTS

Search Outcomes

Figure 1, a modified PRISMA flow chart (2011) demonstrates the numbers of studies and results of the selection and screening process. We found 173 papers through database searches and none that we had not already found through the grey literature or reference lists. After removing duplicates, 121 remained. Of these, 74 studies' titles and abstracts were reviewed, but 54 were not research and were excluded. Full text sources of the remaining 20 were examined to check inclusion and exclusion criteria, and we were left with six papers for possible inclusion. Of those, two were unsuitable because they were reviews, leaving four studies.

Table 1 shows the characteristics of the included studies. We did not find any RCTs or intervention studies. Two quantitative studies that used questionnaires with open-ended questions for qualitative analysis were retained. One study was from America/Canada (Perrin & Kulkin 1996) and three from Australia (Mikhailovich et al. 2001; McNair et al. 2008; Rawsthorne 2009). Two studies focussed on LGBT parents seeking health care for their children while Rawsthorne (2009) and McNair et al.'s (2008) studies were part of an exploration of lesbian parenting.

Settings and Participants

Participants in all of the studies were recruited from the general community; two used questionnaires to assess a range of demographic variables and administer open-ended questions (Perrin & Kulkin 1996; Mikhailovich et al. 2001), while two were individual interview studies (McNair et al. 2008; Rawsthorne 2009). Two included lesbians only (McNair et al. 2008; Rawsthorne 2009) while 5% of Mikhailovich et al.'s (2001) and 11% of Perrin's and Kulkin's (1996) subjects were gay fathers and no studies included bisexual or transgender participants. Only McNair et al. (2008) identified ethnic groups (11 Anglo-Australian, 2 Indigenous Australians, 8 European, 2 Asian, 1 Latino). Children in the families studied ranged from birth to adulthood, but only McNair et al. (2008) interviewed the children. A total 384 respondents from across the four studies are included in this review. No studies focussed on any particular type of health professional or service, although Perrin and Kulkin (1996) refer to paediatricians in their discussion and the paper is published in a medical journal (Perrin is a medical doctor), Rawsthorne (2009) is published in a social work journal, and Mikhailovich et al. (2001) and McNair et al. (2008) lead interdisciplinary teams and are published in generic health and policy journals.

Procedures and Measures

For the two quantitative studies (Perrin & Kulkin 1996; Mikhailovich et al. 2001) some caution is needed, and we debated about their inclusion as their response rates were very low (12% and 20%, respectively). The authors in both studies noted this limitation, but pointed out that such was consistent with previous work in this area, where blanket community mail-outs, which these were, fail to target LGBT persons, and only a proportion of those who identify themselves will return questionnaires.

Mikhailovich et al. (2001) measured satisfaction with care, and indicate that while they found high levels of

TABLE 1
Summary of descriptive studies on use of health services by LGBT parents/families

AUTHOR, YEAR AND COUNTRY	AIMS	SAMPLE	PROCEDURES/MAIN MEASURES	KEY FINDINGS	RECOMMENDATIONS
Mikhailovich et al. 2001, Australia	Examine the experiences of LG parents seeking health care for their children in Australian medical system	92 responses, 82% lesbian families, 5% gay, 13% varied family constellations, 167 children, 6 weeks to 36 years, (64% < 13 years)	Questionnaire, throughout Australia, response rate 23%, demographic data, 2 questions re-satisfaction with care, 7 open-ended questions seeking information re-disclosure of sexual orientation to healthcare providers, affirming/supporting experiences, difficult experiences, and suggestions for improvement of care	89% satisfied to very satisfied with GP care, 62% paediatricians, 61% EDs, 60% all nursing and medical staff during hospital admissions; 16% dissatisfied with EDs, 11% paediatricians, 11% nursing and medical staff during admissions. No links between education level of parents and scores. Main cause of problems around long-term needs for chronic conditions, waiting times, other system-related factors; 76% no problems related to disclosure of parents' sexuality; 27% suffered discrimination, inap-propriate/invasive/excessive questions.	Affirming family diversity; non-assumption that all parents are heterosexual; education of health providers re-LG issues; use of inclusive language and in medical documentation.
Perrin & Kulkin 1996, USA/Canada	Understand the experiences LG parents and their children have had with paediatric healthcare system	255 responses, 84% lesbian mothers, 11% gay, 443 children aged between <1 and 20 years	Questionnaire: 2 sets (1) mail list of community centre (no knowledge of sexuality of subjects), 87 returned of 202 (43%); (2) newsletter LG rights group, 168 returned of 2045 (8%). Open-ended questions and demographics.	45% prefer LG health providers, 31% prefer special clinic for LG parents, 86% reported at least 1 affirming +ve characteristic of their paediatric care, 75% had +ve experiences in clinics and EDs, 78% +ve about hospital experiences. Majority reported +ve interaction with healthcare professionals, but 39% had problems with primary paediatric care, 53% with clinics, 39% with hospital. 40% exclusion of non-biological parent, 77% disclosed sexuality, many parents reported in deficiencies in health services.	Paediatricians encourage parents to develop broad networks of similar families; indicate support by providing information about community groups; supportive education in schools etc. about family diversity; change office environment to include inclusive forms, books, magazines etc.; statement of confidentiality prominent; always see both parents.

(*Continued*)

TABLE 1
(*Continued*)

AUTHOR, YEAR AND COUNTRY	AIMS	SAMPLE	PROCEDURES/MAIN MEASURES	KEY FINDINGS	RECOMMENDATIONS
McNair et al. 2008, Australia	Explore how lesbian parents negotiate the healthcare system	20 families, 36 parents, 43 children 2 months to 38 years (20 participated in study). Ethnic groups identified—11 Anglo-Australian, 2 Indigenous, 8 European, 2 Asian, 1 Latino.	One, single in-depth interview per family, (from 1.5 to 5 hours). Analysis—grounded theory, manual, and N-Vivo, codes of +ve and –ve experiences around health care, into clusters, categories, and sub-categories.	Two themes: (1) dealing with the healthcare system, lack of recognition of lesbian families, legal aspects of parents, non-birth mother, heterosexist assumptions (though no overt homophobia). +ve—acceptance, normality, safety, comfort. Use of protective strategies, united front. (2) Disclosure of sexuality, silence, protection of children, self-exclusion of one parent. "Proud" disclosure, united front upfront, need to be honest, reduce confusion. Passive, orientation less important, indifference to orientation, comfort.	View sexual orientation as a varied context in health care. Make no assumptions about orientation. Do not assume that lesbian mothers all want to disclose. Clarify relationships if two women present with a child. Modify forms and language. Improve education of healthcare providers.
Rawsthorne 2009, Australia	Examine how lesbian-parented families can be supported	17 families, 21 women, children aged from preschool to teenagers; 7 one-child families; 6 had 2 children; rest had more.	Snowball sampling. Semi-structured interviews re-understandings and experiences of lesbian parenting, reconciling work/family, social policy. Interviews 45–90 minutes, N-Vivo for thematic analysis.	Most had +ve experiences of health services for children including recognition of same sex partnership and parenting, "pleasant surprise."	Services facilitate networking amongst lesbian families. Formal systems in, e.g., baby health clinics to foster and support disclosure and inclusion. Services create environment where diversity is the norm. Need exploration of lesbian families from other cultures.

GP = general practitioner; ED = Emergency Department.

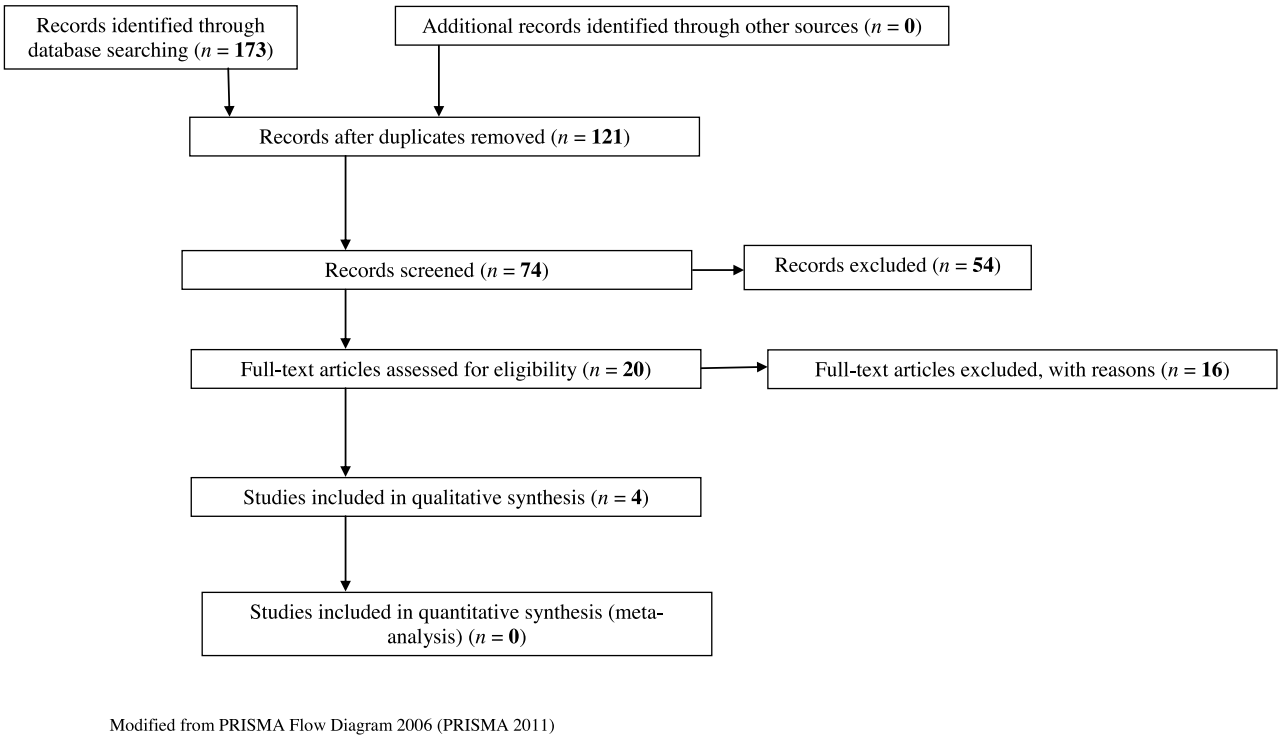

Figure 1. Flow diagram of results of selection process.

satisfaction, they caution about ascribing too much weight to this finding, as it may be influenced by the fact that the health professionals accessed by their respondents were chosen because of their known positive responses to homosexual families (although 23% had not disclosed their sexual orientation). Seven open-ended questions sought information about respondents' disclosure of sexual orientation to healthcare providers, affirming/supporting experiences, difficult experiences, and suggestions for improvement of care.

Perrin and Kulkin (1996) used a questionnaire with four open-ended questions: "(1) what experiences do parents report as especially affirmative and supportive? (2) What experiences do parents report as troublesome? (3) What worries do parents have regarding disclosure of their sexual orientation and family constellation to their paediatricians or other healthcare providers? (4) What suggestions do parents have that would make access to and participation in the process of paediatric care more appropriate to their needs?" (p. 630).

Qualitative studies of McNair et al. (2008) and Rawsthorne (2009) used semi-structured, in-depth interviews with 20 and 17 families, respectively, which were analysed using grounded theory and thematic analysis, respectively.

Findings

Several consistent themes were identified in the included studies (Table 1). While some described problems were likely to be unrelated to sexuality, for example, dissatisfaction with waiting times, most participants found few problems related to disclosure of parents' sexuality to health professionals. A minority felt they had suffered discrimination, including being subject to inappropriate, invasive or excessive questions, and at times a level of ignorance about the needs of LGBT parents seeking health care for their children. However, most had positive experiences, which one family described as "a pleasant surprise" (Rawsthorne 2009, p. 55).

Mikhailovich et al. (2001) found that most respondents were satisfied to very satisfied with different health professionals who provided care for their children: 89% for general practitioners, 62% with paediatricians, 61% with emergency departments, and 60% with all nursing and medical staff during their children's hospital admissions. However, 16% were dissatisfied with emergency departments, 11% with paediatricians, 11% with nursing and medical staff during admissions. No links between education level of parents and scores were apparent, and the main cause of problems centred around families' long-term needs for chronic conditions, waiting times, and other

system-related factors. Importantly, 76% of the parents said they had had no problems related to disclosure of their sexuality, while 27% felt they had suffered discrimination, inappropriate, invasive, or excessive questions.

Perrin and Kulkin (1996) showed that 45% of the parents preferred lesbian and gay health providers, while 31% preferred a special clinic for lesbian and gay parents. At least one characteristic of paediatric care was reported by 86% of the parents, 75% had positive experiences in clinics and emergency departments, and 78% had positive experiences in hospitals where they took their children. The majority reported positive interactions with healthcare professionals, but 39% had problems with primary paediatric health care, 53% with clinics (such as child health clinics), and 39% with hospitals. In those, 40% had suffered exclusion of the non-biological parent, with 77% disclosing their sexuality, and overall, many parents reported deficiencies in health services that may or may not have been associated with sexual orientation.

McNair et al. (2008) discovered two themes, the first around dealing with the healthcare system, where respondents described a lack of recognition of lesbian families, lack of knowledge of the legal aspects of parents, most particularly the non-birth mother, and heterosexist assumptions (though no one described any overt homophobia). Others gave a positive description of acceptance, normality, safety, and comfort. However, parents all described using protective strategies and the importance of showing a united front when taking their children for health care. The second theme centred on disclosure of sexuality; some found it best to remain silent, and all were focussed on protecting their children, often using a technique of self-exclusion of one parent. "Proud" disclosure, with a need to show a united front upfront was important to some; some described a need to be honest, and with the idea of reducing confusion within the health service encounter. Some were more passive, feeling that sexual orientation was either less important than their (their child's) comfort, and that some staff were indifferent to the parents' sexual orientation, which in itself provided comfort.

Rawsthorne (2009) found that most of the parents described positive experiences when seeking health services for their children. This included recognition of same sex partnerships and parenting, and many parents described this as a pleasant surprise.

DISCUSSION

We found only four studies that met our inclusion criteria and explored the experiences of LGBT parents seeking health care for their children (Perrin & Kulkin 1996; Mikhailovich et al. 2001; McNair et al. 2008; Rawsthorne 2009). This finding is significant considering that LGBT families are increasing and their needs and challenges may be different to those of heterosexual families (Ahmann 1999; Perrin et al. 2004; Telingator & Patterson 2008). The findings from the reviewed studies showed that many participants had positive experiences in their interactions with health professionals and services, however, some described problems related to disclosure, discrimination, and staff lacking knowledge (Perrin & Kulkin 1996; Mikhailovich et al. 2001; McNair et al. 2008; Rawsthorne 2009).

The methods of this review were influenced by the confusion of definition of "LGBT." Some investigate only lesbian or gay people, while transgender and bisexual people are often overlooked. This confusion is common throughout the literature, making satisfactory explanation difficult and impossible to generalise to all groups. There may be other subgroups, which are missed altogether. We found no intervention studies of any kind. In other words, there is a great need for intervention studies about the use of health services by families from sexual orientations outside heterosexuality.

While the studies presented here, in the main, found positive aspects of LGBT parents seeking health care for their children, it still remains that in order for health professionals to gain an in-depth understanding of the specific issues and concerns of these vulnerable families, it is important that interventions are developed and tested with empirical research. There are obvious barriers to conducting research in this area and these include (but are not limited to) the silence and invisibility of the families, and most importantly, the lack of funding available to investigate this phenomenon. One important possible limitation (and one we have found in the other studies of which this review is part; Chapman et al. 2011, 2012a, 2012b, 2012c) is that respondents to this type of research commonly come from highly educated, literate populations, who have the skills and assertiveness to successfully negotiate healthcare systems. Different results may be found in LGBT families who are more vulnerable, and, by choice, less visible than the groups captured here, potentially indicating a need for support for themselves and further education for both parents, children, and health professionals.

Disclosing sexual orientation to healthcare staff has been shown to be beneficial; however, if clinicians are homophobic this strategy can have negative results (Perrin et al. 2004; Polek et al. 2008). The authors of three of the four studies we reviewed recommended that healthcare settings and staff provide an environment where LGBT persons can disclose their sexuality (Perrin & Kulkin 1996; Mikhailovich et al. 2001; Rawsthorne 2009). However, we would argue that although providing books and pamphlets and placing stickers and plaques on the office walls to

advertise an LGBT-friendly environment may affirm family diversity, the single most essential strategy is to ensure that staff members receive culturally appropriate education and training (Perrin & Kulkin 1996; McNair et al. 2008).

Knowing or having previously cared for a person who is LGBT increases staff comfort to discuss a client's sexual orientation, lifestyle, and health issues (Sanchez et al. 2006; Shindel et al. 2010). Therefore, it is essential that education strategies be developed that promote opportunities for staff to develop competence in and share concerns related to caring for LGBT clients and their families. In addition, there are many LGBT organisations worldwide (Rainbow Families; PFlag) that provide educational and promotional services and resources. Healthcare professionals could invite these groups to participate in developing and conducting educational and training programmes for staff. This strategy may be one way that health services can ensure that LGBT parents receive holistic, culturally appropriate, and non-prejudicial care for themselves and their children.

A further benefit of engaging with LGBT organisations and the community at large is the opportunity for healthcare providers and professionals to link with these groups and provide relevant and targeted information and assistance to families. McMurray (2007) contends that "as health professionals, it is important that we stay involved in community dialogue, to provide the opportunities for family members to weigh in to debates that affect their health and wellbeing and to transmit helpful information to them. To be of real assistance to families, we must keep issues of concern to them at the centre of public focus" (p. 135).

When a family presents to a health service and is required to complete documentation that provides only normative heterosexist options such as male/female; mother/father, or husband/wife, they are faced with the dilemma of deciding how much information to disclose (Perrin & Kulkin 1996; Mikhailovich et al. 2001). Changing health service policy to introduce or modify documentation that is inclusive of all families is essential. By providing inclusive documentation the service demonstrates to the parents that it is safe to disclose their family constellation.

A further recommendation from the reviewed studies was for healthcare staff to facilitate and encourage parents to develop networks of similar groups and provide information about relevant community groups (Perrin & Kulkin 1996; Rawsthorne 2009). Although identifying relevant resources and providing those in some form to LGBT clients is important, we would argue that most LGBT parents would have experienced long and often difficult journeys to create or maintain their families (Wilton & Kaufmann 2001; Chapman et al. 2011, 2012a, 2012b, 2012c) and as a result are most likely aware of how to access networks and information. Therefore, more concrete measures to support LGBT parents are required.

Appropriately implemented family-centred care (FCC) is an ideal model to provide care for all families (Shields 2010), and nowhere is this more important than for potentially vulnerable families who may not fit within the stereotype of the nuclear, heterosexual family. FCC can be implemented fully only if the health professionals delivering that care are sensitive to the context, functions, and constructs of the family in question (Shields et al. 2007). FCC is especially significant for those families where one or more parents are transgendered or are in the process of transitioning from one sex to another. The voice of transgendered families was clearly missing from the reviewed studies. This oversight, although related to the authors' focus being on either lesbian and gay or lesbian-only perceptions, has resulted in the exclusion of the experience of one important group of parents. Therefore, to ensure that healthcare delivery and services are inclusive of all families it is essential that future studies include the experience of transgendered parents seeking health care for their children. Three of the included studies were conducted in Australia, and while we searched databases of literature from all countries, caution dictates that we resile from claiming generalisability. Another limitation of three of the studies suggests further inquiry. Only one study (McNair et al. 2008) involved the children, and their voices need to be heard. A study of the children's experiences is required.

CONCLUSIONS

Few studies have investigated the experiences of LGBT parents seeking health care for their children, and we found none that studied the effects of specific interventions for these families seeking health care for their children. Although some parents are satisfied with their interactions with health services, many still experience discrimination and prejudice. There are several strategies that healthcare professionals can implement to improve health service delivery and ameliorate the experiences of these parents. These include: provide a safe and inclusive environment; educate staff about gender sensitivity; implement effective FCC; engage with the LGBT community; facilitate and encourage LGBT parents to initiate and maintain networks; and include transgendered parents in future research.

Relevance to Clinical Practice

To provide non-prejudicial, holistic, and effective health care, health professionals are required to ensure their practice is inclusive of all families. Only with the effective

application of inclusive models of care will the families' needs be met.

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